WORLD HEALTH ORGANIZATION

TOBACCO ALERT

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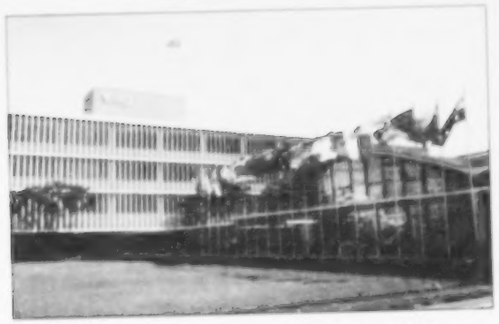
EDITORIAL

TOBACCO CONTROL IN THE WESTERN PACIFIC REGION

Ten years ago, with the exception of Australia, New Zealand and Singapore, virtually no country or area in the Western Pacific had implemented tobacco control measures. Now, although some countries lag behind, by 1992 virtually all countries in the Western Pacific had introduced some health education, especially for young people, and were observing WHO's World No-Tobacco Day; most had created a national coordinating agency on tobacco control, established by the Ministries of Health or run by health associations; all had some legislation or regulations on smoking in public places, especially in schools, government offices and health establishments; most had health warnings on cigarette packets; and several had bans on sales to minors, bans on smokeless tobacco, bans on vending machines, and information on tar and nicotine content printed on the packages. It is still too early for the effects of many of these measures to be translated into reduction of prevalence and especially a reduction of disease, disability and death, but the processes are now in place.

The Western Pacific has shown that measures can be enacted in developing countries, they can be implemented in a relatively short period of time, and they can be effective. In some areas, the Western Pacific has led the way, with Singapore's first ban on advertising in 1971; Hong Kong's ban on the manufacture, importation and sale of smokeless tobacco in 1987; and China's historic decision to ban smoking on all domestic flights as early as 1983. China, important by virtue of being the largest producer and consumer of tobacco in the world, implemented a comprehensive law on tobacco in 1992.



WHO Regional Office for the Western Pacific (WPRO)

These successes have not been achieved easily. While domestic production and consumption of tobacco remain a major problem, the Western Pacific has become the prime target of the transnational commercial tobacco companies because of the Region's large, growing and increasingly affluent population. "Bright Future Predicted for Western Pacific" was the headline in the September 1986 issue of the industry journal *World Tobacco*.

This shows that in the future, there can be no complacency about smoking in the Western Pacific Region for several reasons:

Demographic reasons: Smoking will increase simply because the population in the Western Pacific will increase by approximately 500 million from the current 1.5 billion to 2.0 billion in 2025. So, even if smoking rates remain unchanged, smoking will increase because of demographic reasons. Also, as life expectancy increases (i.e. infectious diseases decline) the effects of the tobacco-related epidemic will be increasingly felt through a proportionate increase in chronic diseases.

Health awareness: Awareness of the harmful effects of tobacco use still remains low in comparison to countries where the epidemic started earlier.

Standard of living: As a country's economic situation improves and individual spending capabilities increase, cigarettes will become more affordable.

Increase in smoking among women: The low level of tobacco use among women in many countries in the Region is not due to high awareness of the health damages of tobacco but merely a consequence of social traditions or shortage of economic resources. Already within countries, the more developed areas often show higher smoking rates than the less developed areas. Finally, the tobacco industry is aggressively targeting women and girls with specific marketing techniques.

Cottage industry to transnational tobacco: The issue is not simply switching from local to foreign brands of cigarettes, but market expansion. When the foreign companies enter a developing country, there is a replacement of a simple, unsophisticated, often rural industry with a powerful, sophisticated transnational company; this replacement is not a neutral change. A further complication is that the national monopolies can quickly learn to mimic techniques, such as advertising, from the transnational cigarette companies. (continued on page 7)

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MONITORING

TOBACCO OR HEALTH SITUATION IN THE WESTERN PACIFIC REGION

Prevalence

Smoking cigarettes is the major method of tobacco use in the Western Pacific Region; pipe smoking and chewing tobacco are much less common practices.

Some countries and areas in the Western Pacific, such as Singapore, Australia and New Zealand, have a long history of action against tobacco and have already seen a decline in smoking. Others have still not undertaken a national prevalence survey, and of those that have, few were earlier than 10 years ago, so that information on trends is scanty. The national tobacco monopoly in Japan started gathering prevalence data in 1958, but only later did governments gather data for health purposes, for example, in Hong Kong in 1982 and China in 1984.

In general it is estimated that about 50% of men and between 2-10% of women in the Western Pacific region smoke cigarettes, but there are considerable variations within this figure. Surveys suggest that more than 60% of adult males smoke in Cambodia, China, South Korea, Fiji, Kiribati, the Philippines, Papua New Guinea and Tonga. Conversely, less than one in three adult males smoke in Australia, Hong Kong, New Zealand and Singapore.

Although overall smoking prevalence among women is estimated to be less than 10%, again there are wide variations. About one in four women smoke in Australia and New Zealand, whereas in several of the Pacific Islands, female prevalence is reportedly much higher. Conversely, only 7% of women smoke in China and less than 5% of women smoke in Hong Kong, Singapore and Vietnam. There may, however, be significant under-reporting of smoking in countries where it is culturally less acceptable for women to smoke. Early indications of a rise of smoking among girls in the region is of great concern. It is of particular concern in Tokyo where 1991 smoking prevalence among 20-29 year old women was estimated to have risen to 23%. Overall, 51% of Tokyo men were smokers in 1991, while smoking prevalence among women in 1991 was 18%.

China assumes considerable importance by virtue of its population size (1.1 billion). Currently, there are approximately 300 million smokers in China. According to the 1984 First National Prevalence Survey, 61% of men and 7% of women smoke. A second National Prevalence Survey was undertaken in 1991-92 on 500 000 people, and the results will be announced in 1993. Preliminary data from Beijing, Shanghai and Tianjin indicate that, while some middle-aged men who become ill from the effects of tobacco are quitting, young adults are smoking as much as in 1984.

Morbidity and mortality

As smoking manufactured cigarettes has been a recent habit in many Western Pacific countries compared with Western countries, and because infectious diseases are still important causes of death in the Region, the full impact of tobacco-related diseases has yet to become evident. Out of the current 3 million deaths each year from tobacco, about 1 million are in developing countries, although there is a considerable degree of uncertainty around this estimate. This global total is expected to rise to 10 million by the year 2025, with 7 million of these deaths in developing countries; of these, more than 2 million will be in China alone.

Studies from countries like Japan and Hong Kong indicate that, for equivalent duration and amount of tobacco smoked, the incidence of many of the tobacco-related diseases are similar to those in Western countries. For example, age-standardized mortality from lung cancer in Japanese women is similar to that of many European countries. As in Scotland and the United States, lung cancer already accounts for more deaths among Japanese women than breast cancer.

Costs

Calculations on the cost of tobacco use have been made in Australia, China, Hong Kong and the Republic of Korea. These studies include the costs to government of medical and health costs, the costs to business and industry by virtue of lost productivity, and the costs to the individual. A study on price elasticity reported from Papua New Guinea in 1990 suggest that raising taxes on cigarettes reduces tobacco consumption even more than in western countries. The decrease in consumption is most marked among the young, because of more limited spending power. Studies from Hong Kong

(continued on page 12)

NEWS BRIEF

SMOKELESS TOBACCO: CHILDREN START EARLY

According to a study just published in the American journal *Pediatrics*, 50% of smokeless tobacco users in parts of the United States of America started before the age of 12. Half of these had chewed tobacco or used snuff for the first time between the ages of 5 and 8 years.

This study, which covered 2018 sixth to ninth grade students (age range 11-16 years) in diverse geographical settings in the rural southern state of Arkansas, found that 242 students, or 12% of the total, had used smokeless tobacco at least twice. Moreover, there are three times as many boys as girls who use tobacco in this way. Smokeless tobacco use is particularly widespread among baseball players and in the rural southern states.

Whereas the manufacturers of smokeless tobacco claim it is not harmful to health, Anita Gottlieb of the Arkansas Children's Hospital in Little Rock is anguished by the fact that a certain number of smokeless tobacco users are likely to contract throat cancer.

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COUNTRY PROGRAMMES

CHINA: AN EMPHASIS ON YOUTH

Prevalence/health data

There are 300 million smokers in China and this number is expected to rise, partly because of demographic reasons, and partly because the female market represents an almost untapped source for future expansion. Thus, peak exposure of the market probably has not occurred, and peak mortality will not occur until well into the next century.

However, the health consequences are already evident, with heart disease, cancer, stroke and respiratory diseases – all tobacco-related – now the commonest causes of death. In addition, the 1984 National Prevalence Survey showed that 40% of non-smokers interviewed were "passive smokers".

Of all the children alive today in China, 50 million are predicted to die prematurely from smoking, even at current smoking levels. But studies in Beijing in the 1980s indicated that smoking was rising rapidly among Chinese adolescents. China is now placing national emphasis on the problem of smoking among youth, with the Third National Symposium on Smoking and Health, held in Beijing in October 1992, and attended by people from many parts of China, focusing entirely on "Youth and Tobacco". Studies presented from all over China show that most children start experimenting with smoking before they are 12 years old, some under the age of 8 years, then move to becoming daily smokers by their late teens or early twenties. Chinese youth are starting to smoke for more or less the same reasons as do children in Western countries. Although girls smoke less than boys, smoking among girls is also increasing, and in some places is high, for example, in Heilongjiang and Wuhan.

Costs of tobacco

Today, China collects more than US $ 5 billion annually in tobacco taxes, making tobacco the largest industrial tax source. Export earnings are steadily increasing and currently standing at US $ 120 million. However, the Chinese Academy of Preventive Medicine has estimated "the health-related economic costs caused by smoking in 1989 were US $ 5 billion," about the same figure as earned from tobacco taxes.

Tobacco control measures

More than three centuries ago, a Chinese philosopher, Fang Yizhi, discussed the dangers of smoking, pointing out that long years of smoking "scorches one's lung". But the anti-smoking campaign in China only began in earnest in 1979, with the issuing of an official Circular on the harmful effects of smoking.

Since then, many conferences and meetings have been held. Delegates from China started liaising with international colleagues and attending the World Conferences on Tobacco or Health from 1985. The first major conference in China was held in Tianjin in 1987, and since 1990 national conferences have been held on topics such as national tobacco control policy, quitting, passive smoking and youth.

The first Anti-smoking Associations were founded in 1987 in Shanghai and Hangzhou. Recognising that the control of all epidemics requires a central, coordinating organization, in 1990 the national Chinese Association on Smoking and Health (CASH) was established. With a relatively small staff it has already established provincial Associations in about half (21) of the provinces; organised the national (and other) conferences; published a regular newsletter that is distributed all over China; and established international contacts with equivalent agencies, as well as many other activities.

Health informational campaigns have gained momentum through the National Institute of Health Education. China has celebrated World No-Tobacco Day each year since 1988. One challenging activity is the quitting project for illiterate farmers in several remote provinces (Chinese Rural Farmers' Quitting Project, *Tobacco Alert*, January 1992).

China's first anti-tobacco law went into effect on 1 January 1992. It has the potential to save more lives in a single country than any other health law in history. The law mandates the reduction of tar in tobacco products, bans or restricts smoking in public transport and in public places, bans smoking by elementary and high school students, requires the printing of tar levels and health warnings on local and imported cigarette packets and bans tobacco advertising on TV and radio and in newspapers and magazines. The law also mandates improved health education about the health effects of smoking, with particular emphasis on young people.

Tobacco control activities in China have received international as well as national support. The World Health Organization, the World Bank, and the International Union Against Cancer, have been particularly active in supporting tobacco control measures and the development of non-communicable diseases surveillance relating to tobacco. Within China, the Minister of Public Health has taken a strong, leadership stance, and the Chinese Association on Smoking and Health, the Chinese Academies of Preventive Medicine and Medical Sciences, and the National Institute of Health Education have been the principal movers in tobacco control activities. The Chao-Yang hospital in Beijing is a collaborating centre of the WHO Tobacco or Health programme.

A journey of 10 000 miles begins with a single step

There is an old Chinese saying: "A journey of 10 000 miles begins with a single step". The first steps in tobacco control have now been taken in China, but there are still many miles ahead.

COUNTRY PROGRAMMES

TOWARDS A SMOKE-FREE PACIFIC

The tranquil islands of the South Pacific have also been successfully targeted by tobacco companies. Smoking has been a part of life since its introduction by European sailors and missionaries. Tobacco was originally used in limited ways based on local production. As in many places transnational tobacco companies have taken over the production and marketing of tobacco. In many areas including *Fiji, Tonga, Kiribati and Western Samoa*, smoking rates especially among men, are high, with prevalence rates of the order of 60-80%. Smoking is still relatively uncommon among women, although in some countries, such as Fiji, female prevalence is already 20%. Advertising is extensive and promotion of tobacco is widespread and on the increase, encouraging the young to take up smoking as a part of Western lifestyle.

Most efforts in *tobacco control* in the Oceania region have focused on education. There is little or no legislation in all but a few of the countries. Raising the profile of smoking as a public health issue and implementing supportive legislation for control of smoking is a part of the necessary action plan.

With technical support from WHO, the *Cook Islands* enacted tobacco legislation in 1987 and have some of the best tobacco control measures in the Pacific. *Papua New Guinea* (PNG) also implemented legislation to control the sale and promotion of cigarettes, but because of evasions of the spirit of the legislation by tobacco companies, the need for further more comprehensive legislation is indicated for the situation to change dramatically. Tobacco tax increases in PNG for a number of years, most recently in 1992, have been shown to significantly reduce tobacco consumption. Further legislation to enhance the country action plan is being prepared in Papua New Guinea. A further problem in PNG is the widespread use of betel nut contributing to high rates of oral cancer.

The second most populous country in the region is *Fiji*, with a population of 760 000. Although the major local crop is sugar, an active tobacco growing area is located in the Sigatoka Valley. In Fiji, in 1991, there were some 500 growers, a Rothmans company factory, known as the Central Manufacturing Company with about 150 employees and a total local production of around 514 million cigarettes. The government tax income was close to US $ 20 million. Government officials now recognize the impact of tobacco on health and are keen to look at ways to diversify the farming.

In October 1992, WHO supported a regional workshop under the Tobacco or Health programme, which focused on options for legislative change. In Fiji some 60% of the adult men smoke, as do 25% of doctors! The customary Kava ceremony is now often a kava and cigarettes ceremony with the younger men the heavier smokers. There is widespread ignorance of the impact of passive smoking. A recent survey in Suva at a leading school for both boys and girls showed that 94% of the students surveyed were unaware of the risks of passive smoke, though up to 45% of their parents and 57% of their close friends were smokers. There are few restrictions on smokers in public buildings or transport, except for one or two recent Ministry of Health recommendations. Already, reported cancer and cardiovascular disease rates are climbing even though it is known that occurrences of these diseases are underreported.

The Ministry of Health have expressed keen support for implementing smoke-free hospitals and health facilities throughout Fiji. Opening the workshop the Minister of State for Health, the Honourable Solomone Naivalu said, "It *is my intention to prepare* a Cabinet Paper on smoking bans in all public places and the banning of cigarette advertising here in Fiji. This will not be an easy task when we consider the economic benefit and health dangers involved".

The workshop recommendations include the implementation of comprehensive health warning labels on all cigarette packets, and the introduction of smoke-free public buildings and transport.

The efforts of the Chief Health Educator from the Ministry of Health in *Western Samoa*, a most active TOH worker, have resulted in leading sports personalities giving their support to World No-Tobacco Day campaigns. For some years her work has been aimed at raising the smoking issue with politicians, community and government leaders.

In 1989, the Government of the *Cook Islands* implemented legislation to control the sale, advertising and promotion of tobacco. This concise piece of legislation was among the first in the Pacific, and sets a pattern for the steps that other Pacific countries can take.

At the above-mentioned workshop it was noted that the toll of tobacco-related disease was beginning to create an impact on Pacific island countries; the future trends will reveal an even bleaker picture. For this reason, it was crucial that action plans be implemented in each of the countries, drawing on the successes from elsewhere to reduce disease rates caused by tobacco use. A much greater use of the TOH resources will contribute greatly to the effectiveness of government and community action.

As a result of the WHO Tobacco or Health programme and of initiatives of the International Union Against Cancer, some changes are taking place. The Melanesian Council of Women took action in 1991 not to use tobacco as part of the traditional exchange of gifts when making visits. The Health Minister for Vanuatu has requested that all imported cigarettes have warning labels at least to the standard of the country of origin. A group of community and health leaders in the Solomon Islands is working on legislative controls. The opportunity for many more countries to become involved in TOH is available and raising the issue with community leaders is the first step. An increasing awareness of the problem with increasing activities to combat the issues raised by tobacco use will lead to improved health for all people in the Pacific islands.

COUNTRY PROGRAMMES

THE PHILIPPINES: ACTION BY NGOS

More than 5 million Filipinos alive today will be killed by tobacco if present consumption trends continue, compared to about 6000 killed by the volcanic eruption of Mount Pinatubo. Tobacco may be one of the greatest national disasters the Philippines can ever expect to experience, yet the epidemic evokes little national interest in comparison with the more dramatic but transient disasters such as floods and volcanic eruptions.

The 1988 National Prevalence Survey showed that 64% of men and 19% of women smoked. A survey of doctors one year earlier showed that 63% of male doctors and 37% of female doctors smoked, with 38% smoking in front of their patients. Overall, tobacco consumption is rising steadily.

Although 7% of total Philippine taxes come from tobacco revenue, smoking-related illness results in added medical care costs of billions of pesos each year. Fifty-six thousand hectares of land was under tobacco cultivation in 1987, which is 0.8% of the total arable land; food aid in cereals the same year was 349 000 tonnes. The tobacco industry estimates that wood-cured tobacco accounts for 55% of the total tobacco production in the Philippines, and deforestation is now a major problem. The costs to the individual smoker are also substantial: it has been estimated that US $ 263 million is spent each year on buying cigarettes in the Philippines. This is, on average, 2.1% of family income, (the percentage would be nearer 12% for families on minimum income) money that could otherwise be spent on food, clothing and shelter.

Tobacco control action in the Philippines commenced in the late 1970s, with symposia held by the Philippine Cancer Society, followed during the 1980s with several health conferences focusing on tobacco, in particular the Annual Tri-Chest Conventions.

In 1986, a Committee was created by the Government to establish smoking control legislation, the first of many committees considering and proposing legislation. In 1988, the Department of Health produced a Position Paper for a Smoke-free Philippines. That same year, the National Coalition on Tobacco Control was formed for a brief period by the Philippine Medical Association, the Tri-Chest Societies and the Philippine Heart Foundation, and representation was made in support of a tobacco control bill before the House of Representatives. To date, no tobacco-control bills have been passed in the Philippines, that is, on advertising and other promotion, health warnings, control of harmful substances, bans on smokeless tobacco, bans on sales to minors, or bans on vending machines.

There have been some achievements, however. Prior to 1991 there were some occasional bans on smoking in public places such as, by local ordinance, many places in Quezon City, the Securities and Exchange Commission, the Department of Health and Congress itself; these bans have usually been up to the initiative of the head of the agency. But in 1991 the Civil Service Commission decreed, in a breakthrough ruling, that all public sector workplaces should be smoke-free, with certain designated smoking areas allowed, however, compliance with this law remains uncertain.

The new Chairman of the Senate Committee on Health, who himself does not allow smoking among any of his staff, is introducing a bill into the Senate that regulates tobacco advertising, with penalties for not obeying the law.

In addition, health societies are gradually becoming involved; health education programmes and cessation workshops have been established by the Department of Health and the Philippine Cancer Society. A single health warning is proposed. In 1988 all domestic flights on Philippine Airways became smoke-free. One major achievement was to secure a Smoke-free South East Asian Games in Manila in 1991. But most of this work is done by a very few individuals and strict national legislation to protect the health and future well-being of Philippine children is still lacking.

In November 1992, the first Philippine National Conference on Tobacco Control was held, jointly sponsored by the Philippine Medical Association, Asian Pacific Association for the Control of Tobacco (APACT) and World Health Organization. The conference brought together about 140 delegates from the Philippines and 20 experts from neighbouring countries or areas. Dr S.T. Han, WHO Regional Director, gave the keynote speech at the meeting, summarizing the health hazards of tobacco, emphasizing the importance of government support and assuring delegates that 'WHO is with you on every front in the fight against smoking'.

At the meeting, the Secretary of Health stated that: "Smoking is one of the top 10 priorities for my tenure" and "I pledge my full support in the campaign for anti-smoking. We should have done it long ago".

WHO/TOH PROGRAMME

UPDATE ON REGIONAL ACTION PLAN ON TOH

Background

In May 1986, the World Health Assembly adopted a resolution which stressed the dangers of tobacco use, called for a global approach to controlling it, and urged Member States to use a nine-point control strategy. In response to this resolution, the first Western Pacific Regional Working Group on Tobacco or Health was convened in Tokyo, Japan, in November 1987, immediately prior to the Seventh World Conference on TOH. It made a series of recommendations on tobacco control programmes in the Region. In March 1990, the second Working Group met in Perth, Western Australia (prior to the Eighth World Conference), and drafted a Regional Action Plan on Tobacco or Health for the period of 1990-1994. The Plan was finalized and distributed in August 1990.

The objectives of the regional plan

The main objectives of the 1990-1994 Action Plan on Tobacco or Health are for the Western Pacific Regional Office to support the following:

- Development and implementation of comprehensive national policies and programmes on tobacco control.
- Collection of data in countries that have not yet done so, especially on prevalence of tobacco use and cost analysis.
- Health education and information.
- National efforts for legislation.
- Development of price policies.
- Identification of existing sources of information within the Region and support for the establishment of a regional information centre.
- Evaluation of progress within the Region at a follow-up Regional Meeting in 1994.

The annual programme

A detailed and practical annual programme was incorporated into the Plan:

During 1990, the first year, the Plan was to be disseminated to all Member States. The names of key individuals in tobacco control were to be sent to Geneva to be included in the circulation of WHO's *Tobacco Alert*. Background information was to be collected from various government ministries. Representation was to be made by WHO for the 1990 Asian Games in Beijing to be smoke-free (and for all subsequent games in the Region).

In 1991, the second year, a survey was to carried out by WHO on all airlines operating Western Pacific routes. A clearinghouse was planned, but unresolved questions of how to finance it have prevented its establishment. All 35 Member States were encouraged to celebrate World No-Tobacco Day, and to implement one additional major health education activity.

In 1992, endorsement by all medical societies, especially the national medical association, was sought, with a simple statement to the effect that smoking was harmful to health; the purpose was to use this as a powerful statement of support. All Member States were to report one new initiative, either the passage of legislation, a major health educational campaign, or a tax increase (at minimum to maintain the real price of cigarettes), and a new annual initiative would be continued for the subsequent years of the Plan.

In 1993, it was hoped that all Member States would have undertaken a national prevalence survey on tobacco use, with additional studies, where possible, on the economic costs of tobacco to the country or area.

By 1994, all Member States would have begun to implement comprehensive national policies on tobacco, including the identification or establishment of a central coordinating person or unit on TOH, preferably within the Ministries of Health; all should have undertaken a national prevalence survey and collected data on tobacco-attributable mortality; at least one quarter would have conducted a cost analysis, even if a simple one, and collected information on import, export, taxation and tobacco farming. Members were encouraged to approach the Food and Agriculture Organization of the United

WHO/TOH PROGRAMME

Nations, the World Bank and other relevant organizations requesting support for feasibility studies on alternative use of land used to grow tobacco; all Member States would have organized annual activities, including WHO's World No-Tobacco Day; and all Member States would have passed two or three items of national legislation on tobacco control, one related to promotional bans.

The goals: countries with a longer history of action against tobacco could aim at a continuing decrease in tobacco use of at least 2%-3% per annum, with an expected reduction in tobacco-related diseases recorded between 1995-1999. Countries or areas that had not hitherto taken significant steps to reduce tobacco use, would aim at establishing and reporting national action against tobacco, with a view to recording reduction in consumption between 1995-1999. An additional goal for all Member states was to prevent an increase in smoking among women in the Region.

The Western Pacific Regional Office of WHO was given a special responsibility to support the implementation of the Plan by providing practical support, such as short-term consultants to assist countries; providing legislative information; forming networks with TOH experts, collaborating centres, non-governmental organizations, and health educational agencies; organizing and supporting meetings and research; publishing progress reports; and holding a subsequent Working Group before the end of the Plan to evaluate progress.

Progress

At the WHO Western Pacific Regional Committee meeting held in Hong Kong in September 1992, the Regional Director reported that progress had been made and that a large number of countries and areas had taken action to achieve some of the targets set by the Action Plan. However, the tasks outlined in the Action Plan had only partly been carried out. The major constraints were identified as TOH programmes still being poorly coordinated, governments in developing countries still feeling the need for a tobacco-related income, and that "significant adverse action has been taken by tobacco companies which apply vast resources and sophisticated marketing techniques to promoting tobacco use".

The Regional Director was able to report on countries that had collected prevalence data and that a few had collected data on cost analysis. All Member States had participated in activities to mark World No-Tobacco Day, and that extensive health educational activities had been undertaken by many Member States. He had written to all the airline companies operating in the Region encouraging them to make their flights smoke-free. Eleven countries and areas had introduced legislative measures, and three had attempted to reduce tobacco use by raising prices.

Future needs

The Regional Director stated that in future, emphasis should continue to be placed on the four key components of tobacco control: (1) comprehensive national policies on tobacco control; (2) health education and information; (3)legislation; and (4) price policy.

WHO's Western Pacific Regional Office will provide on request consultants experienced in tobacco policy to develop and implement national policies, and will support governments in formulating national policies and programmes on tobacco control. It was vital to teach children in the Region that smoking is not a sign of liberation or maturity, whereas the ability to resist psychological pressure is. It was also important to educate decision-makers such as government officials and other key professionals about the hazards of tobacco use and the economic losses due to ill health caused by tobacco use.

Subsequent to the 1992 meeting, a questionnaire was distributed to all Member States to supply information as to their status in the implementation of the Plan.

EDITORIAL

TOBACCO CONTROL IN THE WESTERN PACIFIC REGION

(continued from page 1)

Less protection: Some governments in developing countries may not be fully aware of the degree of the harmfulness of smoking. They are often preoccupied with other health problems, such as high infant mortality or communicable diseases; thus people in developing countries may be left uninformed and unaware of the magnitude of the health risks.

By 2025, seven million of the 10 million annual deaths worldwide caused by tobacco will be in developing countries; more than 2 million of these deaths will be in China. In addition to health problems, the economic costs – to government, to business and industry, to the environment, and to the individual – make it imperative for countries in the Western Pacific to take action to reduce the smoking pandemic. Countries in the Region have clearly demonstrated that, although the battles are tough, they can be won.

COUNTRY PROGRAMMES

SINGAPORE: TOBACCO CONTROL MEASURES "GOVERNMENT LEADERSHIP"

Singapore has been at the forefront of world tobacco control, with increasing and stringent tobacco control legislation following the first ban on cigarette advertising in 1971, twinned with comprehensive health education activities for adults and children.

In the 1970s, many public areas were declared smoke-free and, in 1986, all government offices became no-smoking areas. In 1980 a single health warning on the cigarette packet was introduced. In 1986, the National Smoking Control Campaign was launched, with May designated the Anti-Smoking Campaign month.

Nineteen eighty-nine was a year of intense activity, with the strengthening of the single health warning to four rotating warnings on 20% of the front of cigarette packets; prohibition of smoking in certain public places (hospitals, clinics, restaurants, air conditioned places, including amusement centres, department stores, supermarkets, indoor sports arenas, for example, sports stadia, bowling alleys, billiard rooms, gymnasia and aerobic and fitness centres, and other places); a ceiling of 15 mg of tar and 1.3 mg of nicotine in cigarettes sold locally; and prohibition of sponsorship from tobacco companies, although a let-out clause allowed the Minister of Health to permit such sponsorship.

Nineteen ninety-one saw redoubled effort, with incoming duty free cigarettes banned and import duties substantially increased. Health education campaigns have been linked to the themes chosen for World No-Tobacco Day to maintain public awareness.

In 1992, there was continuing endeavour with extension of no-smoking areas to air-conditioned hairdressing saloons, barber shops, banking halls, restaurants, private buses, private hire buses, school buses and taxis; a ban on foreign magazine tobacco advertisements if the circulation in Singapore is over 10 000 copies (this will later be extended to 5 000 copies); and intense activity during Smoke-Free week, with seminars for doctors, medical students, national service recruits, young people and the adult public. There has been a steady increase in the tax on tobacco, more to reiterate the danger to health than for increased income. In October 1992, Singapore International Airlines (SIA), already operating several no-smoking flights to Asian cities, extended its no-smoking policy to flights connecting Singapore with Dhaka, Calcutta, Kathmandu, Bombay and Perth.

A ban on sales to under-18 year olds and the banning of all vending machines is currently being formulated.

Unfortunately, the ban of tobacco advertisements on television is effectively circumvented by tobacco-sponsored television programmes from Malaysia being beamed into Singapore. A tightening of Malaysia's advertising and sponsorship bans planned for 1993 should reduce this exposure.

Adult prevalence of daily cigarette smoking has dropped from 23% in 1977 (males 42%, females 5%) to 16% in 1991 (males 29%, women 1.5%) – the lowest in the world. Per capita consumption of tobacco was reduced by half between 1980 and 1990. A 1991 survey among secondary and post-secondary students, however, showed a slight increase in smoking, to which the government reacted with commendable and extreme concern.

The Singaporean government is probably unique in that there is not even a pocket of resistance within government to tobacco control but the future is an uncharted path. It is not known whether rates of smoking will now rise or fall and whether any changes from this point onwards will be rapid or slow. Nor are the best approaches known; virtually all identified measures have been tried, the only exceptions being extremely steep price increases and a ban on even the rare and exceptional sponsored event. How to prevent a rise in smoking among women from the very low current rate of 1.5% is a major and formidable challenge. The rest of the world is watching Singapore's future with extreme interest.

NEWS BRIEF

NO SMOKING IN THE WHITE HOUSE

With the inauguration of the new President of the United States of America the anti-smoking lobby has already won a symbolic victory: smoking is now banned in the White House. This decision by President Clinton and his wife comes at an appropriate time, shortly after the publication of a report by the United States Environmental Protection Agency which estimates that each year 3000 non-smokers die from lung cancer caused by other people's smoke. Eminent visitors to the White House will from now on be safe from passive smoking, and the educational effect of this spectacular measure should also benefit the entire population by making further inroads into the use of tobacco in public places.

COUNTRY PROGRAMMES

JAPAN: A LONG HISTORY

Background/prevalence

After a marked cigarette shortage in Japan during and shortly after World War II, prevalence rose rapidly to peak in the mid 1960s at 84% for men and 18% for women. These levels have now fallen to 60% (men) and 13% (women) in 1992. Lung cancer, reflecting these changes 20-30 years later, also increased, and by 1989 was the second most common cancer after cancer of the stomach. In some parts of Japan lung cancer is already the most common cancer.

The first major epidemiological study on passive smoking and lung cancer was reported from Japan by Professor Takeshi Hirayama in 1981. In a cohort study of more than 91 000 non-smoking, married Japanese women aged 40 or above, he found that the wives of heavy smokers had a higher risk of developing lung cancer, and a consumption-response relationship was observed. This pioneering work has been confirmed by multiple studies from all over the world. In Japan itself, it is estimated that almost 2000 women die each year as a result of passive smoking.

Tobacco control measures

The problems of smoking and youth were recognised as long ago as 1900 when the Act for Prohibition of Minors from Smoking was enacted, making smoking under the age of 20 years illegal, a law that is still in effect today. In the 1920s commuting transportation and cinemas became smoke-free by a Fire Prevention Act.

Other tobacco control activities started in the 1970s, initiated by health, non-smokers rights' and lawyers' groups. In 1980 a lawsuit was filed, demanding that National Railways make smoke-free cars in intercity trains, a suit that continued until 1987.

There are now many non-governmental organizations that act in a variety of ways to reduce tobacco use, such as the "Association for Smoking Prevention Education" (1983), the "Physicians and Teachers Association to Protect Children from Tobacco" (1983), "Women's Action on Smoking" (1987); the "Coalition on a Smoke-free Environment for Kids in Japan"(1988); the "NGO Council on Tobacco or Health" (1991), comprising six health authorities: Heart, Cancer, Cancer Research, Tuberculosis, Mother and Child, Health and Fitness; one of its main activities has been to hold symposia on World No-Tobacco Day in cooperation with the Ministry of Health and Welfare, and the National Cancer Center; and finally, the "Japan Medical-Dental Association Against Tobacco" which was established in 1992.

In addition, the Japan Heart Foundation runs anti-smoking seminars and programmes for heart disease prevention, the Japan Anti-Tuberculosis Association has issued a series on anti-smoking; the Aichi Lung Association runs programmes on smoking cessation including a hot line; the Osaka Cancer Prevention and Detection Center holds Stop Smoking Competitions.

Legislation and regulations

In addition to the ban on smoking among youth, there have been some other national laws or regulations, such as in 1985 when the importation of smokeless tobacco was cancelled, or the weak, single, health warning on the cigarette packets advising smokers not to smoke "too much".

In 1987, the Ministry of Health and Welfare published a "White Paper on Tobacco" and formally acknowledged the health hazards of tobacco, enabling other sections of government to introduce tobacco control measures. The second version of this White Paper will be published in 1993.

Regulations for smoke-free areas have been introduced on an ad hoc basis rather than by a national ban. In restaurants, individual managers are making their own regulations, such as in 1984 when the Takashimaya Department Store in Tokyo declared its restaurant smoke free, followed by a similar move in the Mitsukoshi Department Store. Other examples are the MK Taxi Company in Kyoto, which announced all its 454 cabs will be smoke-free in 1992 (see October 1992 issue of *Tobacco Alert*), the first time in Japan that a taxi company adopted a smoke-free policy. In 1992, smoking was prohibited throughout the newly opened 120-room Tokyo Kiba Hotel, the first hotel in the country to ban smoking throughout premises. Also in 1992, railway stations on the Yamanote Line in Tokyo banned smoking, except in small designated areas. Thus, individual tobacco control measures are moving ahead of national legislation.

However, in 1992, an Industrial Safety and Health Law was revised by the Diet, on the initiative of the Ministry of Labour, imposing responsibility on employers to maintain comfortable and safe working circumstances, which included efforts to keep them smoke-free.

The East Japan Railway Co. will ban smoking at all of its stations near Tokyo and major stops in eastern Japan in March 1993, expanding the bans put into effect in August 1992. The number of JR East stations enforcing the ban will increase to 406, where 15 million daily passengers make up 93% of the company's customers.

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COUNTRY PROGRAMMES

JAPAN: A LONG HISTORY

(continued from page 9)

JR East is also planning to expand the ban to 376 other stations where smoking is permitted during limited hours.

Action is being taken by the Hiroshima Medical Association and Teachers' Group for Smoking Prevention Education to ensure that the Twelfth Asian Games to be held in Hiroshima City in October 1994 will be smoke-free.

Health information and education

In 1984 an annual no-smoking week campaign was initiated by grassroots NGOs throughout the country. In 1991, the Ministry of Health and Welfare observed World No-Tobacco Day by turning off 12 of the 17 cigarette vending machines in the ministry building for the entire day (the building houses three other ministries). The Ministry distributed a total of 20 000 posters to medical institutions and public health centres calling for cooperation. The Ministry also requested Japan Railway companies, Japan Nongovernmental Railway Association and airline companies to voluntarily introduce more seats and routes where smoking is prohibited. For the last few years, the Ministry of Health and Welfare has provided Y 20 million/year to the Osaka Cancer Prevention Centre to run prevention and cessation programmes.

In conjunction with World No-Tobacco Day in 1991, members of the Teachers Union at the Tokyo Foreign Languages School went on strike for one hour, demanding a ban on smoking to protect the health of teachers and students. During the strike many teachers carried placards in English saying they would be killed by the smoke from cigarettes.

The Ministry of Education distributed a guidebook for smoke-free education in junior high schools in 1987 and in 1993 will introduce teaching about addictions of tobacco, alcohol and drugs into the junior high school curriculum.

Litigation

Litigation on the basis of harm done by passive smoking has been undertaken. The first lawsuit for a smoke-free workplace was filed in 1985. There are five current law suits demanding smoke-free workplaces; for example, in 1992, a 50-year-old employee sued East Japan Railway Co. seeking injunction against smoking in workplace and Y 10 million in damages. He asked that smoking be banned in the workplace and in the workers' lounge at the station. But in July 1992, an Iwakuni Municipal employee lost a suit seeking a smoking ban in municipal offices and Y 300 000 in damages for his own suffering from passive smoke; the case is under appeal to the Hiroshima Upper Court.

Changes in attitudes towards smoking are taking place, and smoking prevalence is falling. Developments of tobacco control are being achieved by initiatives of government, both of state and local, and NGO-coordinated networks of grassroots and health authorities, researchers, the media, and ordinary people who are victims of passive smoking.

LEGISLATION

TOBACCO CONTROL LEGISLATION IN THE WESTERN PACIFIC REGION

Introduction

Tobacco control legislation in this Region varies from very stringent to non-existent. Some countries and jurisdictions, for example Singapore, Australia, New Zealand and Hong Kong, have a long history of tobacco legislation, and all of these have experienced a significant reduction in the prevalence of smoking. Others, such as the Philippines, have been less successful in their attempts to enact legislation; while others, such as the Lao People's Democratic Republic and Cambodia, often confronted with a wide range of major problems in the health and other spheres, are still in the early stages of considering legislation.

Countries in the Region that have relied principally on health education to combat smoking (such as the Philippines) have been less successful in reducing the tobacco pandemic than others (such as Hong Kong) that have utilized a combined approach involving health education, legislation and pricing policy.

Bans on tobacco promotion

Singapore has implemented the most comprehensive ban on promotion, although this ban is effectively circumvented by the saturation of tobacco company-sponsored television programmes that reach Singapore from Malaysia.

Throughout much of the rest of the Western Pacific, tobacco advertising is still permitted or is only partially banned, bringing sophisticated, seductive, "Western-style" messages to the Region's youth. Tobacco-company sponsorship of sports and the arts is widespread, along with "brand-stretching" – the use of a cigarette name for other goods such as sportswear, men's clothing and holidays. Also, there is a proliferation of cigarette names (or "look-alike" names) on children's sweets, school books and sports items such as frisbees. Product placement, the paid insertion of smoking or tobacco emblems into the narrative in films, occurs in the Region.

Although China's Tobacco Monopoly Law of 1992 states that "Tobacco advertising is banned on TV, radio, newspapers and magazines", advertising continues on billboards, and lighted panels, as well as through sponsorship of sports and the arts and even of health professionals. Weak and partial bans have only weak and partial results.

In contrast, New Zealand's total ban on tobacco advertising, implemented in December 1990, was shown to have decreased tobacco consumption by 8%.

Smoke-free areas in public places

Encouragingly, virtually all countries in the Region have introduced smoke-free areas in public places, especially health premises, government offices and schools. These vary from legislative bans with substantial financial penalties, such as in Hong Kong, to weaker regulations that carry no penalty or are minimally enforced, and thus are often disregarded.

Health warnings

Most countries have introduced health

LEGISLATION

warnings on cigarette packets although there is only a single legend, except in Australia, New Zealand and Singapore. In order to have any effect, health warnings need to be varied and prominent, and most health warnings in the Region (as in the rest of the world) should be strengthened.

Reducing harmful substances

Several countries in the Region, especially those where the cigarettes on the market have very high tar levels, have introduced regulations to lower these levels. In a few countries, including Papua New Guinea, the levels are printed on the packets.

Protection of minors

Smoking by young persons is prohibited in Japan, but the rates of adult smoking are established by the mid-teens, showing the minimal effect of this regulation. Legislation introduced in China in 1992 states that "Students in high schools and elementary schools shall be prohibited from smoking". Australia, New Zealand, Papua New Guinea and Singapore have banned sales to minors. Many other jurisdictions, such as Hong Kong, are debating whether to introduce similar legislation that, while excellent in theory, requires adequate enforcement. There is the additional concern that, by suggesting smoking is only an adult activity, this may encourage some youth, who wish to appear adult or to be daring, to smoke. This dilemma is compounded by the fact that the commercial tobacco companies, for example in Hong Kong, are giving strong support to such legislation, confirming with certainty that such a law may be ineffective.

A few countries in the Region have undertaken other measures aimed at protecting youth, including a ban on automatic vending machines that makes it more difficult for young persons to buy cigarettes; a ban on sales (and smoking) in schools and other places frequented by young people; and a ban on free samples and on the sale of single or loose cigarettes (which young people can more easily afford).

Bans on smokeless tobacco

Chewing or sucking tobacco is less commonly practised in the Western Pacific Region than in certain countries in the South-East Asia Region. Because of the new popularity of smokeless tobacco, however, pre-emptive bans have been enacted by Australia, Hong Kong and New Zealand.

Mandating health education

With the exception of China, few countries mandate health education by law to ensure that it is undertaken throughout the school system, not just left to the interest of individual teachers.

Litigation*

There has been very little litigation in the Region involving cases brought by smokers against tobacco companies for damages for tobacco-related diseases. In Australia, a lung cancer victim dropped such a case when she became too ill to pursue it.

However, there have been two recent cases of particular importance as regards passive smoking. Culminating a five-year multi-million dollar legal battle, an Australian Federal Court judge in Sydney ruled in 1991 that, as a matter of law, passive smoking causes lung cancer, asthma and respiratory disease in young children and, therefore, that a tobacco-company advertisement denying these facts violated Australian law. This was the first time that any court in the world had made a general judgement on the effects of passive smoking.

The case resulted from a legal challenge by the Australian Federation of Consumer Organizations Inc. (AFCO) to a July 1986 advertisement by the Tobacco Institute of Australia (TIA) in 14 newspapers. The advertisement claimed that "There was little evidence and nothing which proves scientifically that cigarette smoke causes diseases in nonsmokers". The Australian Advertising Standards Council forced the TIA to publish a correcting advertisement, but AFCO claimed that TIA's reaction was unsatisfactory and brought a suit in Federal Court. The judge ruled that there is scientific proof that exposure to cigarette smoke causes disease in nonsmokers and that TIA had breached Section 52 of the Trade Practices Act in claiming that there was no evidence that passive smoking causes cancer or other diseases. The Trade Practices Act prohibits advertising that is "misleading or deceptive, or likely to mislead or deceive".

The second case involved personal litigation: the Australian Federal Court again set a significant precedent in 1992 by awarding damages against an employer (a State Department of Health) on the grounds that an employee's health had been damaged by passive smoking in the workplace. These two decisions are hastening progress towards smoke-free workplaces and other public places.

Litigation of this type would be difficult in countries with national state monopolies, as it would effectively mean taking the government of the country to court. However, rulings in one country can have a ripple effect on neighbouring countries, in this case by encouraging employers to provide a safe, smoke-free work environment.

* *See also the article on Japan (page 9)*

NEWS BRIEF

SMOKERS AT RISK OF AMPUTATION ...

It cannot be repeated too often that lung cancer is not the only threat to smokers' health, even if it is the best known one. There is in fact a danger, of which many smokers are unaware, that smoking may cause blocked arteries, whereupon a limb suddenly becomes gangrenous and has to be amputated. Unlike the other diseases produced by tobacco, obstruction of the arteries often occurs without warning. The victim may well be told that it is necessary to amputate just a matter of hours after the onset of the first symptoms. Having lost a leg in this way and threatened with the loss of other limbs Eric Blakesley, a 52-year-old Briton, has described his suffering. After smoking for more than 30 years he is now vehemently anti-tobacco and is endeavouring to make smokers aware of this little-known danger.

APACT

THE THIRD ASIA-PACIFIC CONFERENCE ON TOBACCO OR HEALTH: "TOBACCO-FREE WORLD FOR CHILDREN"

The Third Asia-Pacific Conference on Tobacco or Health is scheduled to be held 6-8 June 1993 in Omiya, Japan. The Conference is organized by the Asia-Pacific Association for the Control of Tobacco (APACT), an international nongovernmental organization.

APACT was born on 12 June 1989 in the midst of tobacco trade disputes. A number of Asian countries concerned by the trade pressure to control foreign tobaccos in their countries formed an international coalition called APACT in an urgent bid to support the Thai Government and people. The first APACT meeting was called "Asian-Pacific Conference on Cigarette Smoking and Health". In its first one-and-a-half years in operation, APACT mobilized moral support for the Thai Government in Asia and other parts of the world. These efforts resulted in the GATT ruling in November 1990.

The GATT ruling brought APACT into its second phase. The focus of tobacco control in the Region is moving from trade matters to creating a wide-ranged national and international coalition against tobacco. "The Second Asia-Pacific Conference on Tobacco and Health", held in Seoul, Korea, in August 1991, provided a great opportunity for mutual exchanges. Health advocates throughout Asia-Pacific, including China, Japan, Viet Nam, Mongolia, and the United States, gathered to discuss ways to "immediately implement aggressive tobacco control programmes which include bans on all cigarette advertising, restrictions on smoking in public places and comprehensive educational and intervention programmes so as to create a tobacco-free Asia-Pacific in the year 2000". To assist in the attainment of these goals, particularly through nongovernmental initiatives, is the main function of APACT. The Third Conference will follow the path that was paved in Seoul in 1991.

Searching for ways of developing the full potential of a national tobacco control movement in each Member Country is the fundamental theme of the Third Conference. It will, therefore, present recent information on the ill-effects of tobacco-use and on the current tobacco control situations in Japan and in other Asian countries such as Thailand. In addition, it will deal with news from the tobacco control fronts in other regions and place special emphasis on women and children and tobacco.

A series of workshops will discuss the roles of medical and co-medical professional groups; consumer organizations, womens' groups, community organizations and the media; and, school health education and youth groups. Roundtable discussions are planned on coalition building for media advocacy, lobbying and legislation; how to prepare simple teaching materials for tobacco-free education; and, practical methods of smoking cessation.

Creating internationally coordinated activities will be the second feature of the programme. Taxation, legislation, tobacco-free air travel, tobacco-free sports events, countering smuggling, and any other topics to be shared by Member Countries will be on the agenda.

"TOBACCO-FREE WORLD FOR CHILDREN"
is the slogan for the Third Conference.
Please join us in making a tobacco-free Asia-Pacific for the next generation!

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MONITORING

TOBACCO OR HEALTH SITUATION IN THE WESTERN PACIFIC REGION

(continued from page 2)

confirm a substantial drop in smoking prevalence following substantial increases in tax.

Evaluation

Few major, community-based anti-smoking programmes have undergone specific evaluation even in developed countries. Evaluation is difficult as often several tobacco control measures are taken simultaneously. Evaluation is even rarer in developing countries, but World No Tobacco Day or specific health programmes have been evaluated in some countries or areas within the Region. There have been few quitting programmes in developing countries and still fewer evaluated; for example, with the one exception of China, all the papers on cessation presented at the Seventh World Conference on Tobacco or Health were from developed countries.

Creating and maintaining a national data base on tobacco and tobacco use is a priority for countries and areas within the Western Pacific, so that they may realise the scope of the pandemic within their own country (a prelude to taking preventive measures) and they may further assess the effects of tobacco control measures taken.

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